A Guide for Parents of Teens with Attention Deficit Hyperactivity Disorder: An Adlerian Approach with a Special Focus on Middle Schoolers

A Research Paper

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for

the Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

By:

Fayemarie Anderson Carter

March, 2014
Abstract

This paper is a review of the effectiveness/usefulness of a manual for parents of teens with Attention Deficit Hyperactivity Disorder (ADHD). The manual discusses ADHD as a neurodevelopmental disorder and explores the resulting deficits in executive functioning as conceptualized by T.E. Brown. The manual also covers the effects of ADHD and co-occurring disorders on the day to day functioning of the adolescent in terms of interpersonal relationships, academic progress and increased susceptibility to engaging in high risk behavior. The manual outlines the basic constructs of positive parenting based on an Adlerian approach gleaned from the works of Alfred Adler, Rudolf Dreikurs, and Jane Nelsen. Finally, the manual provides tools and information for parents to use as they advocate for their teens. Included is information on what to expect from schools, insurance companies and professional caregivers.
A Guide for Parents of Teens with Attention Deficit Hyperactivity Disorder: An Adlerian Approach with a Special Focus on Middle School Aged Children

Attention Deficit Hyperactivity Disorder (ADHD) is the most studied neurodevelopmental disorder among children (Barkley, 1998; Brown, 2013; NIH, 2011). Yet, misinformation and controversy continue to derail efforts to effectively educate the public, medical/mental health professionals, parents and school staff which then affects the availability of adequate treatment for children with ADHD (Arcia, Fernandez, & Jasquez, 2004; Brown, 2008; Nakamura, 2002; Snider & Arrowood, 2003; Stroh, Frankenberger, Cornell-Swanson, Wood, & Pahl, 2008). As a mental health provider and a parent of children diagnosed with ADHD, I found myself professionally and personally faced with many of the same issues such as what approach to take, what information to trust and what providers to use. In his book, Making the System Work for Your Child, Jensen says that on average, parents take between 4-7 years to fully gain the expertise they need to navigate the system in order to procure the necessary resources (Jensen, 2004). The timeframe of 4-7 years suggests that a great opportunity to provide the proper resources/supports, while limiting the frustration and deterioration of relationships, is severely compromised.

Taking the brain’s plasticity (the brain’s ability to make connections in response to stimuli and to mature properly) into consideration, it seems imperative that there should be a way to cut that timeframe of 4-7 years significantly (Nakamura, 2002). Many children with ADHD have difficulty maintaining attention so that they may not be able to learn the skills needed to process information and develop the connections necessary for maturation of the brain (Mishra, Merzenich, & Sagar, 2013; Nakamura, 2002; Roman, 2010). These children can experience
learning delays leading to failure and early dropout; as much as 35% of students with ADHD fail to complete high school (Barkley, 1998; Bash, 2011).

There is no lack of information available about ADHD but since there is a strong genetic component, collecting this information and making decisions can be hard for parents, (Brown, 2013). More often than not, a parent of the child with ADHD also has the diagnosis; about half of the children diagnosed with ADHD have a parent also diagnosed with ADHD (Chronis, 2012; Nakamura, 2002). The implication is that wading through all the information, on top of the day to day stress of parenting children with ADHD, can become very overwhelming for those parents with ADHD, (Chronis, Lahey, Pelham, Williams, & Ralhouz, 2007; Dawson & Guare, 2009). Lack of adequate and accurate information can lead to parents making ineffective choices that further delay proper treatment of their children’s symptoms (Stroh et al, 2008).

Having the right tools and resources available is crucial to treating ADHD because research indicates that untreated, ADHD symptoms can lead to serious social and legal consequences for those diagnosed (Brown, 2013; Schroeder & Kelley, 2009). Teens with untreated ADHD are more likely to become involved in high-risk behavior such as reckless driving; having multiple sex partners and engaging in substance use; experience failure in school/work; have poor interpersonal skills leading to few positive relationships if any; and have legal problems (Centers for Disease Control and Prevention, 2011; Litner, 2003). This has been associated with a higher risk of developing other mental health issues as adults (Brown, 2013; Litner, 2003).

Caregivers, in general, seem to react to this by becoming more punitive, disapproving and controlling (Hectmann, 2004). At the same time, caregivers are also less likely to actively “notice” and reward positive and appropriate behavior (Harvey, Metcalfe, Herbert, & Fanton,
This style of parenting known as the “authoritative style” or “negative parenting” is associated with increased rejection by peers and increased physical aggressions towards peers (Harvey et al, 2011; Kaiser, Pfiffner & McBurnett, 2007). Parents involved in this behavior pattern can experience increased levels of conflict with their child resulting in high levels of stress, health issues, strained relationships leading to divorce, job loss, alienation of friends and other family members, substance abuse, and a general poor quality of life (Webster-Stratton, Reid, & Beauchaine, 2011). Research supports that parent training in positive parenting techniques results in increased appropriate/productive behavior in the teens and improved relationships between parents and children (Healey, Flory, Miller & Halperin, 2011; Sheridan & Dee, 1996).

These following factors taken into consideration make a compelling argument for the need for a manual. 1. On their own, parents can take 4-7 years to learn the ins and outs of getting support. 2. Childhood is short and there is a limited time during which the right opportunities need to be afforded for the proper maturation of the brain. 3. Parents of children with ADHD may also share the genetic link so that symptoms like inattentiveness and distractibility might sabotage even the most determined parent from getting and organizing information in order to make sound decisions. 4. Research shows that untreated ADHD can be quite costly to the child, caregivers and to society as a whole. 5. Research also supports the use of positive parenting with children with ADHD.

**ADHD and Parents**

**National Sources**

I was very careful not to deliberately only find information which supported my beliefs about ADHD or parenting children with ADHD. I searched databases using very broad terms...
like “ADHD and Parenting” and let the research direct what information I would gather and share. Much of the research, although not necessarily presented as Adlerian based, supported exactly what is considered Adlerian, the most useful being the endorsement of positive parenting as having the best results with children with ADHD (Cheong, Pedersen, Molina, Pelham, & Wymbs, 2012; Stroh et al 2008). As such, I integrated several different approaches into what I hope can become a working theory of how to treat ADHD.

**Recognized Experts**

One of the key elements included in the manual is the approach taken by Brown. Brown is the Assistant Clinical Professor of Psychiatry at the Yale University School of Medicine and Associate Director of the Yale Clinic for Attention and Related Disorders. He has written books, presented his findings all over the world and writes regularly for the online magazine additudemag.com. His efforts have been directed towards developing an understanding of ADHD in terms of deficits in the brain’s ability to manage executive functions. He claims that too many still see ADHD as a “lack of will power” rather than the true underlying issue which is impaired brain chemistry (Brown, 2013). He divided these executive functions into six main clusters including: the ability to initiate tasks within a time frame; ability to sustain attention and the ability to regulate emotions in order to complete tasks (Brown, 2008). Brown says that having ADHD is like being a musician in an orchestra without a conductor. All the musicians can play individually but without the right direction, they can’t make great music together (Brown, 2013). So then, a child with ADHD has many capabilities; he/she just cannot effectively use them in order to start an action, follow through, or complete it, without support (Brown, 2013). Understanding that a teen is simply unable to do certain things due to neurobiological processes outside her/his control should change the kinds of expectations that caregivers and
professionals have on teens and result in more realistic and attainable goals (Shaw, Evans, Ekstrand, Sharp, & Blumenthal, 2007).

It is Brown’s Model (Brown, 2008) and his emphasis on executive functioning that led to the focus on middle school aged children. Middle school is such a time of transition (Hoffman, 2009). Developmentally, it is that in between time of not being a child but not being a teen either. The influx of hormones leads to a heightened emotionality, increased impulsivity, sexual awareness, and if that weren’t enough, sleep disregulation (Goodings, Burnett- Heyes, Bird, Viner, & Blakemore, 2012; Konrad, Firk, & Uhlhaas, 2013; National Institute of Mental Health, 2011). Academically, there are more demands on the student (Jacobson, Williford, & Pianta, 2011). No longer do students have a single homeroom teacher. They have 6-7 different teachers and must change classrooms for every subject. There is an increase in workload to balance against an increase in opportunities for extra-curricular activities. Children who may have once had after school care are now expected to be on their own for those hours between school release and when their parents get home (Molina, Arnold, & Vitiello, 2008; Public Broadcasting Systems, 2014; Hoffman, 2009). Middle school demands everything a teen with ADHD already lacks or is just not proficient in (Brown, 2013, Jacobson et al, 2011). All those skills Brown talks about as being underdeveloped in a teen with ADHD are exactly the ones that being in middle school demands. It would seem then that it is very important to provide extra support at this time. It could be very detrimental for an adolescent to experience continued failure and increased conflict with parents and teachers as a result of less than adequate support (Nelson, Young, Young, & Cox, 2010). Providing the right framework, resources and tools can mitigate the effects of such a challenge (Corkum, McKinnon, & Mullane, 2008; Cheong et al, 2012; Jensen, 2004).
Adlerian Parenting Proponents

Adler believed in prevention and in fact was one of the first to promulgate this approach by developing Child Guidance Clinics where he trained parents and teachers to raise children in a way that would develop “social interest” or concern for others and the world we live in (Bitter & Main, 2011). He believed that once children developed that, they would, as adults, act in ways that benefited themselves and society (Nelsen, 1996).

A basic Adlerian premise is that individuals are “indivisible” and so cannot be understood in isolation or only in terms of symptoms and diagnoses but rather within the context of our environment (Dreikurs, 1990). Because Adler believed we are social beings with a desire to “belong” and feel “significant”, he believed we have the responsibility to foster an environment which places value on equality and respect for difference (Carlson, Dinkmeyer, & Johnson, 2008). Without this, a child can become discouraged and act out in maladaptive ways in order to still feel that sense of belonging and significance, what appears to others as “misbehaving” (Dreikurs, 1990; Nelsen, 1996). He believed that if you find the “purpose” of misbehavior rather than a “cause” you can redirect a child to find more positive ways of serving that purpose and meeting his/her needs (Bitter & Main, 2011). Looking at behavior in terms of needs rather than causes is very useful because needs don’t necessarily change and still have to be met (Nelsen, 1996). Eliminating maladaptive behavior necessitates replacement behavior then so that a teen, in an effort to have her/his needs met, doesn’t resort once more to maladaptive ways (Dreikurs, 1990; Nelsen, 1996).

In *Children: The Challenge* by Rudolf Dreikurs (1990) what was striking is how relevant his work still is even fifty years later. This idea he postulates that we just don’t know what to do with our children today because our values have changed so much is still exactly where we seem
to be today. Dreikurs says that we know that the old “do as I say” model just won’t work today in a democratic society but we seem to still struggle with finding a replacement parenting ideology. My own experience as a mental health provider and a parent, together with the conclusions drawn by others in the plethora of research papers and books I have read as a student, make it painfully clear that parents, teachers and caregivers are not in agreement with how to deal children in general, much less children with special needs (Basch, 2011; Carlson et al, 2008; Chronis & Stein, 2012; Harvey et al, 2011; Healey et al, 2011; Webster-Stratton et al, 2011)

A more current Adlerian is Jane Nelsen, who writes as a professional and a parent of seven children in her book Positive Discipline (1996). Nelsen wrote her first book because she found that old parenting techniques just did not work with her children. She found herself using threats, spanking and yelling and still everyone was miserable and nothing was changing. She says that as she was studying Child Development in college, she was excited by the all the information being imparted to her about all the wonderful things she could accomplish with her children but there was nothing showing her how to do it. This is when she was introduced to Adlerian thought and as she began to apply what she was learning, she found that her children were responding so well, that she was able to eliminate most of the negative behavior and found herself once more enjoying being a parent.

Over the years she has shared her knowledge with thousands. Of note is that she explains key concepts as well as provides a failsafe by addressing the ways we could misinterpret or misapply these concepts. That was most evident in how she very carefully outlined the differences between logical consequences and punishment. She tries to make sure that parents don’t, out of habit or stubbornness, disguise punishment as a logical consequence thus
sabotaging the effectiveness of the technique. She does the same in explaining why praise is not useful but that encouragement is. Relating the concepts to real life occurrences is very helpful because it could reduce the amount of frustration and feeling of failure that could happen when a technique is incorrectly applied.

**Other Parenting Experts**

Other sources included *Taking Charge of ADHD* by Russell Barkley (1998); *Making the System Work for Your Child with ADHD* by Peter Jensen (2004); *Smart but Scattered* by Peg Dawson and Richard Guare (2009) and *A New Understanding of ADHD in Children and Adults: Executive Function Impairments* by Thomas Brown (2013). In all of them, there is an urgent appeal for the education of parents and providers about the far reaching consequences of *untreated* ADHD. Brown in his first chapter (Brown, 2013) seeks to dispel over thirty myths about ADHD. It is baffling that there is still so much controversy surrounding even the *existence* of ADHD since it has been discussed in various terms in medical journals since the 18th Century; its symptoms in children were described by Sir George Frederick Still in 1902; and formally treated by Charles Bradley with Benzedrine in 1937 (Pediatrics.com, 2014). In testimony given before the United States House of Representatives, that is exactly what Nakamura discussed (Nakamura, 2002). He presented a statement, signed by scientists from all over the world, asserting there is great concern that even mental health professionals are contributing to the perpetuation of myths surrounding ADHD.

It would follow then there needs to be a more cohesive path for treatment. Some of the case studies I read were about how parents, teachers and mental health providers arrive at the diagnosis of ADHD. Time and time again, teachers interpreted the behavior of the same child differently while parents focused disproportionately more on what was not working and very
little if at all on the strengths of their children (Chronis, Lahey, Pelham, Williams, & Rallouz, 2007; Navarro & Danforth, 2004; Spiro, 2013,). Brown says the problem we continue to face when trying to get support for our children is too many of us still want to treat ADHD as a behavioral disorder when it is a neurodevelopmental disorder (Brown, 2013). There is little to support that Cognitive Behavior Therapy (CBT) works yet it seems the go to for those treating ADHD (National Institute of Mental Health, 2011). The largest study on ADHD, the Multimodal Treatment of Attentions Deficit Hyperactivity Disorder or MTA, has found that parent training in combination with medications seem to have the highest rate of success for treating ADHD (MTA, 1999, 2009). These results have been replicated in other studies (Cheong et al, 2012; Hoffman, 2009, Wilens, et al 2011,). It would seem then that all efforts must be made to facilitate a paradigm shift. The approach to treating ADHD must change from behavior focused to treating ADHD within the context of deficits in executive functioning.

**Advocacy**

A parent can be a child’s strongest advocate. As stated before, even the professionals can’t agree on what to do. Convention was that you leave it to the experts but since the needs of a child with ADHD are so nuanced, especially when additional diagnoses are made, a parent must become a child’s strongest ally in getting his/her child’s needs met (Jensen, 2004). Most children with ADHD will have other co-occurring diagnoses, as many as 70%, so there is a lot to keep up with (National Resource Center, 2003; Patel, Patel & Patel, 2012). What often happens is that a child with ADHD has many different providers and most of them are not in communication with each other, things get overlooked and misdiagnosed (Spiro, 2013) Adler believed the client is the expert on himself/herself. As an extension then, the parent is the expert of the child until such time he/she can advocate for himself/herself. This is why the final part of
the manual discusses how a parent becomes an advocate for his/her child and then ways a child can advocate for himself/herself.

This section takes the approach that everything is relationship based. It talks about ways to interact with medical personnel, mental health providers, insurance companies, and school staff. There is some discussion about communication styles and how to access information and services. Jensen (2004) believes that the parent must take the stance that she/he is everyone’s employer while displaying respect for the expertise of those with whom he/she is working. It’s a tough balance but learning to accept that he/she will make mistakes goes a long way to gaining experience and savvy about being an advocate (Jensen, 2004). Dr. Peter Jensen reminds parents that ADHD, like asthma and diabetes, is chronic. Parents must remember that this is for the long term and many hurdles will need to be overcome. Included in this section is an outline of Jensen’s guiding principles for parent advocates.

Summary

Personal Evaluation

Writing this manual was many years in the making. Perhaps, it wasn’t clear that a manual was how the knowledge I have gained would be encapsulated but I kept collecting data nonetheless. My passion for anything ADHD related is not accidental. My husband and my two children are diagnosed with ADHD as well as co-occurring disorders. In the early years of my marriage we were living in the southern United States. The symptoms were not recognized as ADHD and as a result, a lot of frustration and embarrassment ensued as my children continuously “misbehaved”. There were many looks of disapproval and outright alienation of my children. As time went by, invitations for play dates and birthday parties grew less and less until there weren’t any. Grades suffered and concern deepened.
Even as I attended graduate school in Mississippi, no answers came to me. It was not until I attended Adler Graduate School, Minnesota that in one of my first classes, someone suggested that my children might have ADHD. My first reaction was not one of relief, but rather one of horror. It was as if someone gave me a death sentence. All I had was my experience in Louisiana and Mississippi where ADHD was what “bad children” had. It was what happened when children had really bad parents who could not discipline them and “raise ‘em right”. I was ever more determined to employ every behavior modification technique I could find using sticker charts, coupon books, and token economies all with dismal results. Much to my frustration, many websites, some notable, still espouse these techniques as an important part of treating ADHD. Finally, we were all put on a better path as my younger daughter was diagnosed and then consequently the others.

We all experienced relief at finally having a name for this “thing” but that was not the “all inclusive” answer we would have wanted it to be. There was a lot of figuring things out and learning who and what to trust. Some therapists helped, some definitely didn’t. Some psychiatrists were more willing to try different medications; others weren’t. Sometimes the teachers were at their wits’ end having tried every intervention and both girls ended up needing day treatment at different points. I could have used a manual like this very one I wrote.

When I worked as a mental health provider in a classroom with students with emotional and behavior disorders, parents pretty much said the same thing. By the time they get a diagnosis, they are at the end of their rope and just want the experts to take over. Then when it doesn’t quite work that way, given that we are working with children and not treatment plans, frustration is just too inadequate a word to describe what one experiences. Supervisors want measureable results to justify the money we charge the schools; schools need those numbers too
to justify the existence of the programs to the school board and so on. How does one measure latent learning and prove inadequate chemistry in the brain without brain scans and the like? Had I the knowledge of Brown’s Model at the time, I would have been more sure in my estimation of the issues and “progress”. ADHD was only superficially discussed in those terms and usually more vaguely under the umbrella of “delayed brain development”. The emphasis was always on behavior interventions that just went nowhere, often seeing less than 50% compliance. Even if I couldn’t have directly changed the school’s approach, I could have better educated my parents as to how to respond to their children as well as emphasized the right types of resources being used and accommodations being made in the Individualized Education Plans (IEP’s).

Writing this manual forced me to take everything I “know” and put it in terms of supporting statistics, research findings and well established constructs. It has been quite beneficial in this way since it can serve me well as a professional and as a parent. I now have a working set of organized information from which to draw whenever I might need to lend support to others or to simply remind myself as a parent when I find myself wavering and unsure of what to do.

**Participants Evaluation**

Copies of the manual were distributed in several ways: on a personal blog, at a parent-led group as well as individually to parents of children with ADHD and providers who work with children and families. Readers found it easy to follow, understand and said that in general, they learned a lot of new things they feel they can apply.

**Proposed Improvements**

One overall criticism was that there was not enough time at the oral presentation for questions. There was a delay at the beginning of the group session as we waited for other
members to come. As such we ran out of time at the end for clarifications and questions. This taught me that I need to be less accommodating to those who are delayed because it affects those who did show up on time ready to learn. My responsibility should be from now on to the ones who show up on time first, then to others as time and opportunity allows. I am sure this lesson will serve me well in the future.

Another shortcoming was that the venue did not have a way for me to do a PowerPoint presentation. It couldn’t helped this time around because of various circumstances but in the future, I would definitely want to make sure that there is enough time to plan around those kinds of issues. I felt that my ability to be a little more at ease in my presentation was limited by this. I had to refer to the manual very often, which pulled my attention from my audience as I had to keep looking down at the pages, rather than simply point at something and expound. To make sure this does not happen again, I definitely need better technology available to me. The more comfortable I am, the more comfortable my audience will be.

**Future Plans for the Manual**

This manual is part of my final requirements for completion of my Master’s degree in Counseling. Even if I never shared it with anyone again, it has already accomplished so much in my personal journey of learning and developing my own approach to therapy. In the process, I gained new insight, solidified others and laid the groundwork for more investigation and continued growth. Writing this manual has reignited a certain passion to reach out to parents of children with ADHD, not only from the weird intimate yet anonymous world of the internet on my blog, but once more providing services as a mental health provider. It has been two years since I have worked in the field. It is time to go back, this time with a firmer grasp on the
Adlerian approach and more in depth knowledge about research findings with regards to brain development.

As for sharing the manual, of course I will. I firmly believe as Adler did that in order to accomplish anything with one client, there must be a supportive environment in which he/she should live. The only way to do that is to take every opportunity to educate everyone about the benefits of a democratic society which extends respect, acceptance of difference and concern for others. This is an ideology which supports the development of positive parenting as the standard. That goal is very expansive of course so as my contribution, I will start by making my manual accessible via my blog and look into the possibility of getting it officially published. I hope to use it as a resource with clients as well as a presentation tool. It’s been in the back of my mind for some time, to create a relationship between schools and the mental health community with the singular intent of educating school staff in a greater understanding of ADHD and more effective ways of supporting students and parents.

One thing I would like to add would be a section perhaps at the end, about self-care. I think that as I watched the manual grow in length, I tried to keep the topics to a tighter scope but that is an aspect that could definitely be included. It is a very useful lesson for parents to teach their teens to take care of their bodies and prepare their minds for the work of everyday life. Modeling that healthy lifestyle definitely benefits everyone as it teaches how to handle stress and withdraw and recharge in a purposeful, planned manner. Indeed, that could be a whole manual all by itself.

Change takes time and can appear not to be taking place at all. How does one determine which changes are most important and how does one go about it or measure it or knows when it has been affected? It is easy to become overwhelmed with the complex challenges presented by
ADHD. It has such far reaching effects on so many. It could be easy to forget all the wonderful things ADHD allows for like creativity; different ways of interpreting data, revealing things not otherwise observed; risk taking which leads to discoveries made by the adventurous and so on. It is to all our benefit then that we lend support which allows our children with ADHD to develop those skills necessary to become productive members of our society. Hopefully, manuals like mine, continued research and community outreach efforts will get us closer to that end.
References


Originally published 1964, New York, Hawthorne.


ADHD AND PARENTING

Aerzteblatt International 110(25), 425-431.


Spiro, L. (2013) *The most common misdiagnosis in children: When symptoms have multiple...*


